

## DEPARTMENT OF HEALTH

### TELECOMMUTING FORMS

#### TELECOMMUTING FEASIBILITY REQUEST

This request is designed to assist the employee and supervisor in determining the appropriateness of telecommuting for a specific employee. The employee and supervisor must review the Department's Telecommuting Policy prior to completion of this request. Section I should be completed by the employee. Section II should be completed by the supervisor.

##### Section I (TO BE COMPLETED BY EMPLOYEE)

1. Attach current performance plan. Briefly describe any revisions that might be necessary to accommodate telecommuting.
  
2. What are the specific assignments/duties to be completed utilizing the telecommuting arrangement?
  
3. Describe the equipment/software, if any, needed at the alternative work site necessary for your telecommuting arrangement. (E.g. personal computer, terminal, telephone line, modem, etc.)
  
4. Describe the proposed office arrangement at your alternative work site. (location, furniture, etc.)
  
5. What is your proposed work schedule at the alternative work site? If different from work schedule, identify hours available for telephone contact.

6. What is the anticipated duration of the telecommuting arrangement?
7. Describe plans for ensuring confidentiality/security.
8. Other information not specified above:

## Section II (TO BE COMPLETED BY SUPERVISOR)

1. Does the employee meet the eligibility requirements?
2. What are the benefits (direct and indirect) expected to be derived from the telecommuting arrangement.
3. How do you expect to evaluate/monitor work completed at the alternative work site? What are your plans for supervising the telecommuting employee?
4. Please list estimated costs of equipment, hardware, software etc. to be used and identify funding source or payor:  
Hardware:

Software:

Equipment:

Signatures:

Supervisor

Date

Employee

Date

Division Director

Date

cc: personnel file

## TELECOMMUTING AGREEMENT

This Agreement specifies the provisions of the telecommuting arrangement for

Employee Name

Time period for Telecommuting arrangement

The effective date:

End date:

Specific assignments/duties to be completed at the alternative work site

The employee agrees to complete work as specified in the attached Performance Plan.

Alternative work site

The employee agrees to abide by the following work schedule at the alternative work site:

Hours available for telephone contact:

Address/Location of alternative work site:

### Cost coverage

The following telecommuting costs will be covered by the State:

The following telecommuting costs will be covered by the employee:

### Other provisions

If problems with equipment/software, etc. occur that prevent the telecommuter from completing their work at the alternative work site, the telecommuter must contact their supervisor immediately.

Agreement to comply with applicable statutes, policies

The provisions of the Telecommuting Policy are incorporated into this Agreement.

The employee has read, understands and agrees to comply with the provisions of the Telecommuting Policy and other applicable state and federal laws and policies. (Human Resource Management Rules, Travel policies)

### Signatures

Employee

Date

Supervisor

Date

Divisions/Office Director or designee

Date